TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Houston Orthopedic Surgical

Respondent Name
Hartford Insurance Company

MFDR Tracking Number
M4-15-3350-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Your claimant required ER services after having surgery here 7/7/14."

Amount in Dispute: $766.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A PLN 11 was filed 03/10/15 accepting L4-5 disc herniation only and disputing left knee and all other body parts, conditions, diagnoses or symptoms as compensable."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 28, 2014	Emergency Room Services	$766.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - AUTH – Payment denied/reduced for absence of or exceeded pre-certification/authorization
   - 193 – Original payment decision is being maintained

Issues

1. Did the respondent raise a new denial reason?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. In its response to medical fee dispute resolution, the respondent states that "A PLN 11 was filed 03/10/15 accepting L4-5 disc herniation only and disputing left knee and all other body parts, conditions, diagnoses or symptoms as compensable." The services in dispute were not denied on the Explanation of Benefits for compensability. 28 Texas Administrative Code §133.307 (d)(2)(F) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section." For that reason, the carrier's position regarding compensability will not be considered in this review.

2. The insurance carrier denied the disputed services with claim adjustment reason code AUTH – "Payment denied/reduced for absence of or exceeded pre-certification/authorization." 28 Texas Administrative Code §133.2 (5)states "Emergency - Either a medical or mental health emergency as follows:

   (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

   (i) placing the patient's health or bodily functions in serious jeopardy, or

   (ii) serious dysfunction of any body organ or part;

   Review of the "Emergency Physician Record" finds;

   a. ↑3 days after walking
   b. Severity: moderate

   The Division finds the submitted documentation does not meet the definition of an emergency. 28 Texas Administrative Code §134.600 (p) states, Non-emergency health care requiring preauthorization includes:

   (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;
   (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

   The carriers' denial is supported as the definition of an emergency was not met, prior authorization was required.

3. 28 Texas Administrative Code §134.600 (c) states, The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

   (1) listed in subsection (p) or (q) of this section only when the following situations occur:

   (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

   The requirements of Rule 134.600 were not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.